Adult Social Care and Health Select Committee

A meeting of the Adult Social Care and Health Select Committee was held on Tuesday 22 November 2022.

Present: Cllr Evaline Cunningham (Chair), Cllr Clare Gamble (Vice-Chair), Cllr Ray Godwin, Cllr Lynn Hall, Cllr Mohammed Javed, Cllr Steve Matthews, Cllr Paul Weston

Officers: Darren Boyd, Gary Woods (CS)

Also in attendance: Lindsey Robertson, Elaine Gouk (North Tees and Hartlepool NHS Foundation Trust)

Apologies: Cllr Jacky Bright

1	**Evacuation Procedure** The evacuation procedure was noted.
2	**Declarations of Interest** There were no interests declared.
3	**Minutes of the meeting held on 11 October 2022** Consideration was given to the minutes from the Committee meeting held on 11 October 2022. AGREED that the minutes of the meeting on 11 October 2022 be approved as a correct record and signed by the Chair.
4	**North Tees and Hartlepool NHS Foundation Trust: Maternity Services** Representatives of North Tees and Hartlepool NHS Foundation Trust (NTHFT) were in attendance to address the Committee following recent issues raised by the Care Quality Commission (CQC) in relation to the Trust's maternity services. As well as responding to the published CQC report, NTHFT had also been asked to inform Members how it had reacted to the high-profile Ockenden Report, published earlier in 2022 following an independent review of maternity services at the Shrewsbury and Telford Hospital NHS Trust, which included a number of recommendations for all NHS Trusts. Led by the NTHFT Chief Nurse / Director of Patient Safety and Quality, and supported by the Trust's Consultant Obstetrician and Gynaecologist, a presentation was given which highlighted the following: • Maternity Services: The Trust manages around 2,500 births per year (with an average of approximately 45 taking place at the freestanding midwifery unit (Rowan Suite) in Hartlepool), though this was slightly lower than in previous years and reflected a reducing birth rate. An established pre-natal programme was in place which aimed to counter local deprivation factors (i.e. high smoking prevalence at birth and obesity levels which can

increase the risk of gestational diabetes), the rates of which mean more mothers have to deliver at the University Hospital of North Tees site (where more midwifery resources are thus situated).

- Hospital Services: The offer at both the Hartlepool and the North Tees sites was outlined, the latter also including a level 1 special care baby unit for babies born during or after the thirtieth week of pregnancy (it was noted that babies born before 30 weeks are transferred to the South Tees Hospitals NHS Foundation Trust (STHFT) site, the James Cook University Hospital, Middlesbrough), as well as a dedicated bereavement suite.

- Ockenden Reports: Previously, NHS Trusts were assessed against the outcomes of the 2015 Kirkup inquiry into Morecambe Bay. In recent years, the high-profile Ockenden review following events at Shrewsbury and Telford Hospital NHS Trust saw an interim report released in December 2020 which recommended seven immediate and essential actions (with an associated 12 clinical priorities) for all Trusts – NTHFT was currently compliant with sixth of these seven actions (11 out of the 12 clinical priorities), with a plan in place for compliance with the remaining action. The final Ockenden report was published in March 2022 and contained 15 recommendations (with 92 associated actions) for all Trusts – NTHFT was making progress on these.

  Assurance was given that NTHFT provided a safe, open and transparent service which thoroughly investigated any incidents and actively sought maternity voices to shape the offer. There was also a desire to ensure that services did not sit in silos, and the Trust's Board was regularly sighted on daily maternity developments and the progress being made in relation to service culture and leadership. Key elements moving forward included increased understanding of how best to present / act upon data and creating / maintaining a workforce with the right skills mix. Work on these had begun upon the release of the Ockenden reports, though the Trust was advised to wait for the publication of the subsequent East Kent review.

- East Kent Report: Published in October 2022, an independent investigation of maternity and neonatal services in East Kent identified issues around culture and leadership, standards of clinical and organisational behaviour (looking good while doing badly), and flawed team working. Finding signals amongst the 'noise' was a key element of monitoring performance, and NTHFT had itself tried to create a psychologically safe environment where staff could raise concerns. The Trust recognised that culture could significantly impact upon the delivery of care and had embarked on a new programme to establish if the right leadership structure was in place or whether an alternative approach was required – this involved the input of an independent consultant midwife.

- CQC Rating and 5 Must-Dos: After the latest CQC inspection (published in September 2022), NTHFT maternity services saw its rating reduced to 'Requires Improvement' overall, with four of the five domains downgraded from 'Good' to 'Requires Improvement' (it was stressed that the CQC was not concerned with the safety of care). Five actions which the Trust were

required to take were listed – these involved ensuring effective governance structures, appropriate midwifery leadership, appropriately trained specialist midwives, systems to actively assess and review staffing (and improve retention), and that care was in line with national guidance / best practice.

Whilst many of the issues raised were not unique to NTHFT and were more a result of how services had long been shaped, it was disappointing for the team, and the Trust overall, to be downgraded, as well as a surprise considering it was already aware of the areas for strengthening (it was noted that NTHFT submitted over 200 extra pieces of evidence but, whilst around 70% of this material was upheld, there was no change to the CQCs rating). There had been a number of negative stories involving the UKs maternity services in the national media, and NTHFT was working closely with the CQC and regional colleagues to give assurance about existing provision. Key to this was enabling regular dialogue with staff rather than waiting for concerns to be raised.

Other areas of focus included understanding workforce requirements within the service (significant improvement already made in this regard), enabling the escalation of any concerns on a daily basis, and a live system allowing staff to be relocated to meet service demand pressures. Issues had arisen with some guideline wording (this had since been corrected), and the Trust would also consider how staff were able to articulate the strengths of the service to the regulator, where required, in the future.

- Maternity Improvement Work: A summary of measures to improve the existing NTHFT maternity offer was reiterated, and it was noted that a Director of Governance had been brought in for additional scrutiny and to support the Trust's 'Board to ward' ethos, as well as a new (recently appointed) Associate Director of Midwifery. NHS England support via a national maternity improvement advisor was highlighted – this involved two / three days per week input for a year and would report directly to the NTHFT Board. The Trust had also commissioned a company to undertake a piece of work on the culture within the service, and maintaining staff morale in response to the recent CQC report had been an important focus.

  Closing the presentation, assurance was given around the external governance processes that already existed around services, and that NTHFT was active within this framework. The Trust had previously evidenced developments in relation to quality improvement, and its work on culture had been recognised regionally.

Referencing the unrest over NTHFT governance publicised earlier in 2022, the Committee asked if this had prompted the CQCs latest inspection. Officers stated that the Trust had been open and honest about the leadership difficulties it had faced, and although assurances had been given, the regulator would eventually want to test this. It was also noted that the last CQC visit considered children and young people services as well as the maternity offer.

Members reflected on the assurance given in relation to staffing levels which, whilst positive and in contrast to many areas of health and social care

	provision, raised the question of why the maternity service had been downgraded. Emphasising that the existing offer was still good, the Trust reiterated its safe staffing escalation plan which was an accurate tool for assessing staffing need. However, it was recognised that there was a national shortage of midwives, and the importance of acting on national reports regarding maternity care, having adequately funded services, and getting maternity voices heard were all reinforced. The Committee was surprised to hear of the declining local birth rate, particularly given that Stockton-on-Tees was often seen as the growth Borough within the Tees Valley. Praising the development of the Hartlepool unit as part of the overall maternity offer, Members were keen to compare the Borough's smoking and obesity rates in comparison to other areas – in response, the Trust noted its smoking cessation support for mothers, as well as its use of Public Health midwives in an attempt to address these overarching health factors. Members were also reassured by the regional networking between maternity services, with escalation of cases to the RVI in Newcastle (where required) in addition to those transferred to the James Cook University Hospital in Middlesbrough. NTHFT also liaised with neighbouring Trusts to relieve pressure during high-demand periods. Continuing the theme of underlying health indicators, the Committee asked if the Trust also examined alcohol and drug abuse during pregnancy. Officers confirmed that NTHFT used a screening tool for a host of factors, and also signposted mothers to other services where appropriate. The Trust's own Director of Public Health worked closely with maternity colleagues which allowed the service to tailor its offer and also promote equity of access (how and where the service engages with an individual). Following-up on the stated intention to ensure the voice of maternity services was heard, the Committee queried if there was any data available on this. NTHFT advised that, although in its early days, this objective had developed within the last year, with a Maternity Improvement Group in place (the Chair of which was involved in recent appointments to the service) and the seeking of views via multiple platforms (including social media). Plans for progressing this further had been submitted to the CQC who the Trust hope re-visit in the near future to assess the work undertaken in response to their recent findings. Reflecting on a familiar theme within health and social care at present, the Committee questioned what recruitment and retention measures the Trust had in place. Members heard that a variety of methods were used to ensure staff numbers and skill levels were maintained, including employment fairs, training programmes, preceptorship programmes, and the development of more flexible packages of working (previously work patterns had been quite strict). NTHFT was trying to accommodate different shifts (though has to patch this together to provide a robust service) and was undertaking a pilot where staff rota their own shifts. 'Legacy mentoring' (pairing junior staff up with more experienced members of the workforce) was also offered, and it was recognised that if the right type of support was in place at the start of an individual's employment, the Trust was more likely to retain them.

	Moving onto the issue of accountability, and noting that such a report from the regulator could either be a springboard for change or a missed opportunity, the Committee sought clarity as to whether NTHFT really understood why the issues raised by the CQC had come about, and how it was proactively going to learn, move forward, and ensure the identified concerns were not repeated. Assurance was given that the Trust had structures in place to understand the information available to it and that it was often systems which were failing as opposed to people. NTHFT was keen not to develop a blame culture, instead wishing to promote the safe and confident raising of concerns (and acknowledging of mistakes) which would be visibly acted upon – this was something the maternity service was leading the way on within the Trust. Officers also expressed disappointment that the positives noted by the CQC (which were relayed to the Trust) were not included within their published report. The Committee thanked the NTHFT representatives for their presentation and subsequent responses to Member comments / questions, and looked forward to hearing of future developments in relation to the local maternity offer. AGREED that the NTHFT maternity services information be noted.
5	**Care Quality Commission (CQC) Inspection Results – Quarterly Summary (Q2 2022-2023)** Consideration was given to the latest quarterly summary regarding CQC inspections within the Borough. Ten inspection reports were published during this period (July to September 2022 (inclusive)), and specific attention was drawn to the following: • Allison House: The overall service maintained its 'Good' rating since the previous rated inspection that was published in 2019, with the 'safe' domain improving from 'Requires Improvement' to 'Good'. • Teesside Supported Living: The overall service maintained its 'Good' rating since the previous rated inspection that was published in 2019, though the 'well-led' domain was downgraded from 'Good' to 'Requires Improvement'. Inconsistency with the management and leadership was highlighted, and governance processes were found to not always be effective. Ongoing issues with medicines management was identified during the inspection. • Primrose Court Nursing Home: The overall service remained 'Requires Improvement', the same grade it received following the previous rated inspection that was published in 2020. However, the 'caring' domain was downgraded from 'Good' to 'Requires Improvement', and the 'safe' domain was downgraded from 'Requires Improvement' to 'Inadequate'. Four breaches of regulations had been found, two of which resulted in warning notices being issued. The home was currently in the Responding to and Addressing Serious Concerns (RASC) protocol under the Teeswide Safeguarding Adults Board (TSAB) guidelines from 18 October 2022, with an Action Plan due to be completed on 1 December 2022.

- Stockton Lodge Care Home: The rating for the overall service had improved to 'Good' since the last published report in 2019 when it was graded 'Requires Improvement'. The provider was no longer in breach of regulations, and the service was now safe, managed medicines well, was consistently managed and well-led, and now had a more effective quality assurance system in place.

The Committee voiced its concern about the situation at Primrose Court which, as a nursing home, supported some of the most vulnerable people within the Borough. The appropriateness of the length of time (nearly two years) between this latest inspection and the last published report was discussed, and whilst it was acknowledged that the COVID pandemic did not help matters, Members stressed the need for the CQC to maintain robust oversight, particularly of services which are failing to address identified issues.

In a related question, Members asked for confirmation of how many settings within the Borough were currently under an embargo which prevented them admitting new residents. Officers advised that two services had such restrictions at present, Primrose Court itself and Roseworth Lodge Care Home.

Noting the briefing report for Excellence Home Care, the Committee expressed concerns about the reference to the CQCs new approach to reviewing and assessing performance of some care at home providers which does not involve a physical visit to the office location. Members again emphasised the importance of the Council's own PAMMS assessments in light of these developments.

Attention was then drawn to the PAMMS Assessment Reports section (Appendix 2) – this contained five inspection outcomes that had been published during the July to September 2022 period. Whilst broadly positive findings had been recorded for Wellburn House, Allington House and Roseville Care Centre (all of which were graded 'Good' overall), both Mandale Care Home and Highfield (Stockton) required improvement. The former was placed into the TSAB Responding to and Addressing Serious Concerns (RASC) protocol in July 2022 (though was removed in September 2022 following improvements), whilst the latter had not had a consistent manager since the previous PAMMS inspection in 2021.

With reference to the leadership inconsistencies experienced at Highfield (Stockton), the Committee asked what the underlying reasons were. Members heard that this was difficult to ascertain (possibly better pay elsewhere, or staff stepping-up to a managerial position but not taking to it), and that the Quality Assurance and Compliance (QuAC) Team were working with the Council's Transformation Managers to introduce an induction pack for new managers which includes various avenues of support. Members also noted that the last CQC rated inspection for Highfield (Stockton) was published in October 2018.

The Committee highlighted the fact that four of the five PAMMS assessments published in this quarter had seen providers being given 'Requires Improvement' for the 'suitability of staffing' domain. It was explained that this was due to staff not being deployed in the best areas within a setting as

	opposed to there being an overall shortage of staff. AGREED that the Care Quality Commission (CQC) Inspection Results – Quarterly Summary (Q2 2022-2023) report be noted.
6	**Regional Health Scrutiny Update** Consideration was given to the latest Regional Health Scrutiny Update report summarising developments regarding the Tees Valley Joint Health Scrutiny Committee, the Sustainability and Transformation Plan (STP) / Integrated Care System (ICS) Joint Health Scrutiny Committee, and the North East Regional Health Scrutiny Committee. Attention was drawn to the following: • Tees Valley Joint Health Scrutiny Committee: The last Committee meeting was held on 23 September 2022 where Members considered a Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) Clinical and Quality Journey update, an ICS presentation, an Urgent and Emergency Care Access proposal (regarding James Cook University Hospital), and a Paediatric Ophthalmology Services update. To enable the Committee to learn more about local health-related statistics, an informal briefing session was held in early-November 2022 which included key data being used to inform proposals for Urgent and Emergency Care, along with a further Integrated Care System (ICS) update. The next formal Committee meeting was scheduled for 16 December 2022 and was anticipated to include a North East Ambulance Service (NEAS) performance update and a general overview of winter preparations. The Committee Chair reminded Members that senior TEWV personnel were also scheduled to present a response to recently published Care Quality Commission (CQC) reports regarding their wards for adults with a learning disability or autism, and their forensic inpatient or secure wards, at the next Joint Committee meeting on 16 December 2022. It was proposed, and agreed, that the three SBC Members who sit on the Joint Committee meet after this presentation to discuss TEWVs response and bring their collective views to the next Adult Social Care and Health Select Committee meeting later in December 2022. • Sustainability and Transformation Plan (STP) / Integrated Care System (ICS) Joint Health Scrutiny Committee: Following a lengthy hiatus, Durham County Council (who support this Joint Committee) contacted scrutiny teams across the region in November 2022 with the intention of arranging a meeting for late-November / early-December 2022. However, following liaison with senior NENC ICB representatives, it was deemed that in light of the ongoing ICS briefings to the Tees Valley Joint Health Scrutiny Committee, a meeting of this Joint Committee (which involved similar Councillors) was likely to be a duplication and would not add value. Members expressed frustration that this Joint Committee had not had the opportunity to meet, particularly since it had originally included North Yorkshire County Council which shared an interest in TEWV matters due to the Trust's

	existing footprint. It was also noted that TEWV Governors needed to be held to account regarding the longstanding issues raised in relation to its provision. AGREED that the Regional Health Scrutiny Update report be noted.
7	**Work Programme 2022-2023** Consideration was given to the Committee's current Work Programme. The next meeting was scheduled for 20 December 2022 and would feature the annual presentation by Care Quality Commission (CQC) representatives on their State of Care Annual Report (2021-2022), as well as consideration of the draft final report following the Committee's Care at Home review. AGREED that the Adult Social Care and Health Select Committee Work Programme 2022-2023 be noted.
8	**Chair's Update** The Chair had no further updates.